HRST Orientation for MD Providers and Families Q&A Document
As of 10/30/2015

Q. How can I access HRST online?
A. Users can access the HRST database after completing the HRST Online Rater Training. Users targeted to complete this training will be sent information to begin the online training from HRST support staff.

Q. Who will be administering the HRST with individuals supported by providers in Maryland? Service Coordination?
A. The initial and subsequent HRSTs must be completed by a trained "rater" that has completed the online HRST rater training. The rater may be the Coordinator of Community Services (Coordinator) <u>OR</u> it may be the RN Case Manager/Delegating Nurse (RN CM/DN) employed or contracting with, a Res. Hab. provider.

- **For people in Res. Hab., it is expected to typically be an RN CM/DN employed or contracting with the Res. Hab. provider**
- **For people in SDS, it may be the Coordinator <u>OR</u> it may be the RN CM/DN contracted through Self Directed Services (SDS).**

Q. In case no change in health status, where do I document goals met?
A. Each of the 22 rating items found in the HRST has a comment section. This allows users a place to input details about the status of that item. Comments must be complete sentences that are person centered in nature.

Q. Will additional funding be given to case coordinators for the cost of training?
A. Coordinators will be able to bill for the time spent administering the HRST after they have completed the online training to become a rater. The time required to complete the training is considered to be bundled into the rate.

Q. What is a Q- Score?
A. The Q-score is a unique item in the HRST. Unlike the other 21 items, the Q-score can only be scored a "0" or a "4". This item is designed to capture medical treatments that by their very nature are risky and thus require the involvement of clinical personnel. It also captures those who require exceptional support around challenging behaviors. The Q-score has a direct impact on the overall Health Care Level for the individual.

Q. What security provisions are in place to secure the privacy of individuals that are screened?

A. Data Security in HRST is implemented on many levels. User access to the system is controlled by login ID and password. Passwords are stored in an encrypted form (md5 algorithm) in the database and cannot be deciphered. Only the user knows his or her password. Transmission to and from the HRST website is protected by an SSL certificate using 128-bit encryption, the strongest available. The server that hosts the HRST website is protected by a firewall, and has its own Linux-based security protocols, such as user ID and password authentication. The server is housed in a secure facility in Norcross, GA, that requires card key access. The database is backed up nightly, and the backup files are sent to a server with identical security setup as the live production server. Within HRST, user access to consumer data is controlled by a concept called "scope". A user's scope is set to a value that limits their view of the data appropriate for their role. For example, a Coordination Supervisor may have scope that allows them to see all records for the individuals served by their agency. A Coordinator may have scope that restricts them to seeing only the records of individuals they serve, by specific assignment. No user is able to view records for which they have not been explicitly granted permission.

Q. Can a superior/manager access records that were created by others?

A. Yes, as long as the individual records were created by personnel employed by the same agency as that of that superior/manager and the agency gatekeeper has vetted the access of the superior/manager.

Q. Will HRST impact matrix scores, or vice versa?

A. There are currently no plans to study or create a crosswalk between the IIRS(Matrix) and the HRST.

Q. How does HRST analysis compare to the Adult Evaluation and Review Services (AERS) tool?

A. The AERS tool is used to determine if the person meets Medical Day Hab criteria or in the Preadmission Screening and Resident Review (PASRR) process to assure that people with Intellectual Disabilities are not inappropriately admitted to Skilled Nursing Facilities The two tools have different purposes. HRST has been specifically designed to screen for health risk and to intervene early to prevent the necessity of higher levels of care.

Q. What triggers the initial use of the HRST? Do all of the individuals we support have to have one?

A. The first wave of individuals (a.k.a "the target group") to receive an HRST screening will be those who are in Residential Habilitation (Res.Hab.) services and people in Self Directed Services (SDS). Over the next three years, the goal is for all Community Pathways Waiver Participants to have been screened using the HRST,

Q. Do supported employment providers have to do this as well?
A. Initially, only those waiver participants who are in Residential Habilitation services and people in Self Directed Services will be screened using the HRST. In later implementation phases, waiver participants who are in other types of waiver services will be screened.

Q. What is the timeline for HRST to be implemented in Maryland?
A. The goal is for all people in the target group to be screened by ~~January 15, 2016~~. DDA has adjusted this timeline and are now expecting the target group to be screened by <u>April 1, 2016.</u>

Q. What is your recommendation for how often the screener should be interacting/observing the individual to effectively complete the screening tool regardless of clinical background or not?
A. To complete a screening using the HRST it is not required that the rater know the person. As long as the rater has access to those who do know the person or other basic information a screening can be completed. Even if information is scarce initially, the HRST can be accessed and updated as more information in learned.

Q. I am a Parent Provider in Self Directed Services for my disabled son, and he has had the required HRST completed by the approved RN given to us from the DDA, but she is still a private contractor, requiring payment at time of service. The required assessment funding was approved and is a part of his budget, but we still have not been able to receive reimbursement for the fee she charged. Do you have any information on that?
A. We know that this has been an issue for people in Self Directed Services. You should speak directly with your Regional Office to resolve it. We are working to correct this problem for the future, but in the meantime DDA will work through the difficulties in each region on a case by case basis.

Q. I realize this is intended for the non-licensed people working with an individual, and it can be done prior to the annual IP. However, who is expected to be responsible for it? Should we assume that all Coordinators will be doing this, many of our clients are not in residential services.
A. The initial and subsequent HRSTs must be completed by a trained "rater" that has completed the online HRST rater training. The rater may be the Coordinator of

Community Services (Coordinator) OR it may be the RN Case Manager/Delegating Nurse (RN CM/DN) employed or contracting with, a Res. Hab. provider or the person in Self Direction.

Q. Will information from this system be able to integrate into the state's database?
A. There will be a data transfer between PCIS2 and HRST. The PCIS2 will update HRST on a regular basis, but will remain separate in all other ways.

Q. How does the DDA client request an HRST?
A. DDA clients should work with their Coordinator to obtain an HRST.

Q. How often is it recommended that a person be evaluated by the HRST?
A. At LEAST annually. However, the HRST should be updated as changes occur that affect the Medications, Diagnosis, or any of the 22 rating items.

Q. Are there costs that they provider will have to pay for the training that is required for this software and any upgrades to the system or is this funded by the state?
A. The online training is being provided free to Coordinators and RN CM/DNs. The training requires 8-10 hours and there is no direct reimbursement for this time. The training and the application are both web based so that all that is required is the internet. DDA believes that providers will appreciate the power of the application to assist in the management of their agency and may come to agree that the time spent in training was a good investment.

Q. How does it help address the Final rule?
A. More information on the CMS Final Rule can be found by accessing the HRST website at hrstonline.com, click on the Product tab, then click on Service Planning.

Q. Quality of life is directly related to quality of health… are we going to find this aspect integrated into the DDA's transformation and moving forward endeavor?
A. We agree that health and wellness are fundamental to Self-Determination, Self-Advocacy, Supporting Families, Employment, and Independent Supported Living. DDA

anticipates that the HRST will assist in supporting health and wellness so that the people we serve can pursue these larger goals.

Q. What happens when a staff leaves the agency employ? Do they still have access to this info?
A. Providers are highly encouraged to send an email to mdsupport@hrstonline.com anytime a user leaves an agency and no longer needs access to the HRST. DDA is strongly encouraging each provider to designate a "gatekeeper" to oversee the access to the Protected Health Information (PHI) of the people served in that provider that will be contained in HRST. While HRST has taken many precautions to protect the data once it reaches their servers, providers must protect the data access at the user entry point. HRST will work with you to assure this is accomplished.

Q. Do you have any stats to prove reliability of this tool?
A. Information pertaining to the reliability of the tool can be requested by emailing mdclinassist@hrstonline.com

Q. If providers are decided to be the responsible entity for completing the HRST screenings, has any thought been put into the HRST replacing the required 45-day nursing assessments, in order to prevent duplication of work and errors e.g., nursing review info not matching the HRST info on individual.
A. The HRST is not a replacement the 45 day review which are a requirement of COMAR 10.27.11.04 (c). The HRST is a screening for risk not a comprehensive assessment as required for RN delegation of nursing tasks to unlicensed support staff. DDA anticipates that the Monthly Data Tracker that is a component of the HRST will assist the RN CM/DN with making the regular reviews more accurate and thorough. This will lend itself to determining the most appropriate nursing plan of care to address the current health risks and needs for the person and will identify the training needs of the support staff working with the person.

Q. What about NH/facility based discharges?
A. People entering Community Pathways Residential Habilitation or Self Directed Services from a Nursing Facility will be screened by the HRST during the first year. People entering any other Community Pathways services, from a Nursing Facility, will also be screened in the future implementation schedule.

Q. Does this documentation/system require Adult Care Center?
A. An AERs evaluation is required to obtain services from Adult Medical Day Habilitation. The DDA Adult Day Habs are not yet required to complete HRST for individuals but will be as the 3 year implementation proceeds.

Q. Will each CCS agency be able to run a report showing how many of the individuals targeted for HRSTs in this first wave, need an HRST or have received the HRST? So the CCS's have goals for getting everyone evaluated.
A. Initially, only the target group will be loaded into the HRST for screening. As we progress in the implementation, it will be possible for designated staff within the TCM and Provider agencies, who have not been trained at raters, to have "view only" access to the data for that agency.

Q. What is the inter-rater reliability of HRST? Example, the eating question asks if it is dangerous for the person to eat… My perception of "danger" may be different from another person's perspective of "danger".
A. The questions that are related to each of the 22 items are very objective. As these questions are answered the application removes scoring options that do not apply. This improves accuracy. The Clinical Review process is also designed to catch potential errors in scoring.

Q. Sounds like although this is a screening tool, it is being used also as a health management system. Is that correct?
A. Yes. The HRST can be used in various ways. States use the HRST to monitor health risk and destabilization so as to respond accordingly and appropriately.

Q. What happens if Provider/RN refuses? Ideally would be great for the team to decide but am concerned of some providers not wanting to due to it potentially being an additional cost to them.
A. DDA has acquired the HRST to assist Providers in meeting the Health and Welfare needs of the people they serve. Assuring CMS that the Health and Welfare of the people we serve is being closely monitored is a requirement of having the Community Pathways waiver which is the source of income for all Providers in the DDA system. DDA is certain that when Providers become more familiar with the value of the HRST, they will be enthusiastic about integrating it into their agency. The matter of cost has been addressed in a different question.

Q. How does info from a 45-day nursing assessment get incorporated into this system?
A. The HRST should assist the RN CM/DN in clearing specifying all the tasks under delegation and all the training that needs to be accomplished with the direct care staff. The Monthly Data Tracker should assist the RN CM/DN in accumulating data more efficiently. If during a 45 day review, and RN CM/DN becomes aware that there has been a health care level change that was not captured in the interim between reviews, the HRST can be immediately accessed online and updated.

Q. How is the "Medically Fragile" determination made and how is it separate from the HCL?
A. Medical fragility was demonstrated in the webinar presentation to show how the application can be customized by Maryland to capture data points of interest. Medical fragility is not directly tied to the Health Care Level but if utilized can be included in reports along with HCL for analysis. "Medically Fragile" is not a term clearly defined in Maryland. However, the tool identifies health risk and these risks are viewed through the prism of the Maryland Nurse Practice Act and the RN involved during the clinical review to determine whether the skills required to maintain health are able to be delegated to unlicensed staff or require a nurse (LPN/RN) to complete the skills needed.

Q. Will this be incorporated into the PCIS data base?
A. No….there are no plans at this time to incorporate HRST into PCIS2. DDA will send regular updates of client information from PCIS to HRST, but HRST results will not be uploaded to PCIS2 except as they are referred to in the IP.

Q. I think it is just as important to just say the RN is responsible or the Coordination is responsible, to avoid any confusion or conflict.
A. DDA wants to clearly state that the Coordinator is responsible for assuring the HRST is completed and integrated into the thinking of the team as plans are developed and reviewed. The RN CM/DN is a critical member of that team in supporting the person's health and welfare. DDA expects teams to work together for the benefit of the person being served.

Q. What is Maryland's plan to ensure the basic demo/about me info is consistent between HRST and LTSS/PCIS2? Will the various systems in Maryland be able to import/export data to each other?

A. Data will be imported into HRST from PCIS2. The data fields to transfer have been agreed upon between DDA and HRS, Inc.. PCIS2 will update HRST on a regular basis. To optimize data reliability PCIS2 must be kept accurately.

Q. What, if any, is the relationship between the HRST and the Supports Intensity Scale and/or Maryland's Matrix System?

A. The HRST and the SIS can be used together whether for determining service delivery or resource allocation. HRS, Inc. has training designed to show how these tools work together. Using the tools together gives a comprehensive approach on service delivery. The HRST also works hand-in-hand with person centered tools.

Q. What is the state's recommendation on how a CCS is to ensure a provider's RN completes or reviews the HRST when they have no real authority over the provider's nurse?

A. If the provider's RN is the RN CM/DN for that person, she has a professional obligation to monitor the health status of that individual using the community standard of care. DDA's adoption of the HRST establishes it as one of those community standards. Individual conflicts should be brought to the attention of the Regional Office RN.

Q. How can the coordinator do the ratings when they often don't know the individuals either, especially as the newly entered services and given the high turnover in coordinators?

A. Completing an HRST screening does not require the rater to know the person. The rater can pull information from a variety of sources. As more information is learned about the person, the HRST can be easily updated.

Q. Who determines who is going to do the rating?

A. DDA has made the determination based on the experience of other states that have implemented the HRST.

Q. How many of the early adapter nurses are in SMRO?

A. The early adapter nurses were recruited by the Regional RN. In SMRO, three were recruited.

Q. Can agencies have more raters than just nurses?
A. Coordinator's can also be designated as raters. Residential Habilitation provider agencies should NOT submit user information for non-RN CM/DNs.

Q. If a student asks an BPS Trainer during training did he or she process any knowledge of HRST, should we direct them to HRST Orientation for the Maryland Providers and Families?
A. There is a great deal of information about the HRST on the DDA website http://dda.dhmh.maryland.gov/SitePages/Home.aspx in the right hand column.

Q. Please speak on Maryland's implementation, especially how this will affect self-directed budgets. Families have not yet been reimbursed for HRST and self-medication assessments required to enter self-directed services in FY2016. Individuals already in self-directed services have been told these are required and the funds MUST come out of their current budgets—no additional funds will be provided by the State for this. This is concerning since an RN will need to review it annually and when a RFSC is submitted,
A. If there is nurse delegation already accounted for in the budget for the person, then the HRST is accounted for, ie the RN is responsible, as part of delegation and Maryland standard of practice now, to complete this tool. If there is no RN and there is no need for RN delegation or desire for RN consultation accounted for in the budget, the Community Coordinator of Services has been trained to complete the HRST and can do so annually.

Q. What is the cost for each rater? Overall cost to the Agency for using the HRST?
A. There is no direct cost for use of the HRST to rater or to agency. Completion of the HRST should be incorporated in the job expectation/description of the RN working with people in the agency and this is accounted for in the administrative rate.

Q. I would be interested in seeing a scale of what SDS delegating nurses are being paid across Maryland after this is implemented to know if my daughter's nurse is being paid adequately. She is a valuable part of the team and deserves appropriate compensation.
A. DDA professional rate is currently $30.44 per hour. Each provider agency contracts with the RNs they employ and DDA does not have access to this information. DDA is undertaking a rate setting study that will review all of the rates being paid by MD DDA.

Q. How will the HRST database support current PCIS 2 database (for IP purposes)? Will it be duplication or part of the IP document?
A. The document is to be reviewed and the information included in the IP as part of the planning and implementation of health related risks and activities.

Q. How can a person with an HRST needs and don't [have] insurance and don't qualify?
A. HRST identifies and evaluates risk related to medical conditions, it does not relate to obtaining insurance or qualifying for eligibility.

Q. What type of records could be generated and could these reports tie into the paperwork required for audits from the state?
A. The HRST online application has a suite of nearly 90 reports accessible to the user. The application also contains a feature called Report Builder which allows users to build and schedule their own reports. How this might be used in a state audit functions has not yet been considered.

Q. It would be helpful to discuss how the HRST analysis compares to the Adult Evaluation and Review Services (AERS) tool.
A. The tool used by AERS is for the purpose of evaluating the need for a nursing facility, Medical Day Care or used in Community First Choice is a snapshot of functional status for last 3 days. It does not evaluate risk based on health condition or status. The HRST looks at function and risk related to conditions, function and health over the last year.

Q. The memo says the training has to be completed by 11/1/15. But the second webinar (scheduled by DDA) isn't until 11/9/15. Is that an error in the memo, or am I missing something?
A. Thanks for checking the details. Both are correct. The webinar isn't really related to the people who need to be trained. The webinar is for all comers. The training is for Coordinators and RN CM/DNs.

Q. When everyone receives their access links, can our agency do this training together as a group, or do all of the CCS need to do it individually?
A. Everyone has to do it individually at a computer to be visible to HRST as having successfully completed the training. There are self tests, etc. that have to passed in order to successfully complete the training. It would be possible to do it individually but together in a group format to talk it through as the group progressed through the training. This seems like a good idea and a bit more fun.

Q. I know DDA is going to submit a waiver addendum for nursing. I presume that the HRST is a precursor for the implementation of this new waiver service. I also presume that by implementing this new waiver addendum for nursing, DDA is recognizing that nursing is not part of any rate system. Therefore, if an individual receives a certain score, I think a 3 that this automatically mean that the individual needs nursing and DDA is prepared to fund this service.
A. DDA is about to initiate a rate study. The information provided by the Health Risk Screening Tool will be considered in that study.

Q. Can you tell me what the Nurse training for the HRST is going to cost?
A. Only your time. There is no cost to a nurse or agency. The procedure for accessing training went out to Targeted Case Management Agency Training Coordinators, Residential-Habilitation Agency Executive Directors and the Residential-Habilitation Agency Quality Assurance contact on 10/2/2015.

Q. Can NON-Nurse Residential Habilitation Agency staff be trained as raters?
A. NO-that is not the plan at this time

Q. Can NON-Nurse Residential Habilitation Agency staff have access to the data accumulated for their agency?
A. YES Once we are past the training phase, it will be possible for Designated Residential Habilitation Agency Personnel (who are designated by the agency gatekeeper) to have View Only Access to the data pertaining to their agency. Those Designated Agency Personnel will be able to pull individual reports as well as aggregated reports about the Health Care Screening Ratings for the people served by their agency.

Q. I am listed as the contact so I was not sure how to enter this to let DDA know when nurses change. My assistant who would be doing so should I not be available. That is why we entered the names on the form. The form was a bit confusing in that way. How will DDA know the email for the provider contact to give the monthly updates.

A. Because access to the HRST system creates access to Personal Health Information (PHI), and Personal Identifying Information (PII), it involves Confidentiality and HIPPA concerns that require the highest level of oversight and scrutiny. DDA would prefer that this oversight not be a delegated task. DDA has requested that each Res-Hab Agency and each TCM agency designate a gatekeeper to attest that the user information that the gatekeeper is submitting grants access only to those legally justified to have it. It may be necessary to have 2 gatekeepers per agency. HRST will develop a database of agency gatekeeper emails and will only act on emails sent from those addresses. HRST should be informed of any pertinent agency staffing change by an email from the gatekeeper email address to mdsupport@hrstonline.com. The Regional Nurse should also be informed simultaneously of changes in agency or SDS RN CM/DNs.

Q. Since many SD Budgets do not include nursing, and those that do may not currently include sufficient resources for the HRST, what fiscal or other supports will DDA provide so that a HRST Trained RN is part of the SD person's team?

A. DDA has an obligation to assure CMS that the health and welfare needs of waiver participants are being met. People in Self Directed Services (SDS) are waiver participants and will be screened with the HRST during the first year of implementation. The HRST screening will be used to plan for the health care needs of those individuals in SDS including the training of the Direct Care Staff and whether there is a need for an RN CM/DN. These needs will be reflected in the budget.

Q. Many of the RNs that are in the SD Budgets will need at least the formal HRST rater training. What is the process for this to occur?

A. DDA agrees and enthusiastically supports the training of all RN CM/DNs to become raters and reviewers. The RN CM/DNs working in SDS have been somewhat harder to identify than those working with agencies. Those that we are currently aware of are being directed to their Regional RN as the access point to training. Going forward, this process is likely to change. DDA would welcome suggestions on how to best identify the RN CM/DN currently working in SDS who should justifiably have access to the PII and PHI of the person in SDS.

Q. Will the Direct Care staff in SD Budgets need to complete the brief HRST training and be expected to implement the Monthly Tracking Date form and process to include reporting of significant events? The RN is to be timely notified of all significant events.

A. Yes